PRINTED: 08/28/2015 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC SUMMARY STATEMENT OF DEFICIENCIES SHOWN A 6015 NORRESON, IN 46015 SEACH DEPICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION) FROULT ON THE PROVIDER'S PLAN OF CORRECTION PROPRIETY TAG REQUILATORY OR LSC IDENTIFYING INFORMATION) [W 000] INITIAL COMMENTS This visit was for a post certification revisit to a post certification revisit to a pro-determined full recertification revisit ompleted on 7710/15 to the investigation of complaint #IN00172930 completed on 502/15. This visit was in conjunction with a post certification revisit to a pro-determined full recertification and state licensure survey. COMPLAINT #IN00172930: Not corrected. Dates of Survey: August 17 and 18, 2015. Facility number: 0002711 Provider number: 100243430 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. (W 191) 483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. This STANDARD is not met as evidenced by: Based upon observation, interview and record review for 2 of 4 sampled clients (client G), the facility failed ensure staff were trained to competency to implement and document client C's risk plan and interventions to prevent pressure wounds and failed to provide clients A and C, and for 1 additional client (client G), the facility failed ensure staff were trained to competency to implement and document client C's risk plan and interventions to prevent pressure wounds and failed to provide clients A and C their prescribed diet with pureed consistency. Findings include: 1. The facility's propris to the Bureau of		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE S	
MAIL OF PROVIDER OR SUPPLIER REM OCCAZIO LLC ONLY SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE \$11 COUNTRY CLUB LN ANDERSON, IN 46015 ANDERS			15G251	B. WING				
PREFIX TAG REQUATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS This visit was for a post certification revisit to a post certification revisit completed on 7/10/15 to the investigation of complaint #IN00172930 completed on 5/21/15. This visit was in conjunction with a post certification revisit to a pro-determined full recertification revisit to a pre-determined full recertification and state licensure survey. COMPLAINT #IN00172930: Not corrected. Dates of Survey: August 17 and 18, 2015. Facility number: 000771 Provider number: 15G251 AIM number: 100243430 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9, 483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients behavioral needs. This STANDARD is not met as evidenced by: Based upon observation, interview and record review for 2 of 4 sampled clients (clients A and C), and for 1 additional client (client S), the facility failed ensure staff were trained to competency to implement and document client C's risk plan and interventions to prevent pressure wounds and failed to provide clients A and G their prescribed client with pureed consistency. Findings include: 1. The facility's reports to the Bureau of			100-01		511 COUNTRY CLUB LN	DE	<u> 0671</u>	16/2015
This visit was for a post certification revisit to a post certification revisit completed on 7/10/15 to the investigation of complaint #IN00172930 completed on 5/21/15. This visit was in conjunction with a post certification revisit to a pre-determined full recertification revisit to a pre-determined full recertification and state licensure survey. COMPLAINT #IN00172930: Not corrected. Dates of Survey: August 17 and 18, 2015. Facility number: 000771 Provider number: 150251 AIM number: 100243430 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. 483.430(e)(2) STAFF TRAINING PROGRAM {W 191} For employees who work with clients, training must focus on skills and competencies directed toward clients behavioral needs. This STANDARD is not met as evidenced by: Based upon observation, interview and record review for 2 of 4 sampled clients (clients A and C), and for 1 additional client (client G), the facility failed ensure staff were trained to competency to implement and document client (CS risk plan and interventions to prevent pressure wounds and failed to provide clients A and G their prescribed diet with pureed ocusistency. Findings include: 1. The facility's reports to the Bureau of	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIA		COMPLETION
post certification revisit completed on 7/10/15 to the investigation of complaint #IN00172930 completed on 5/21/15. This visit was in conjunction with a post certification revisit to a pre-determined full recertification and state licensure survey. COMPLAINT #IN00172930: Not corrected. Dates of Survey: August 17 and 18, 2015. Facility number: 000771 Provider number: 15G251 AIM number: 100243430 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. 483.430(e)(2) STAFF TRAINING PROGRAM {W 191} For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. This STANDARD is not met as evidenced by: Based upon observation, interview and record review for 2 of 4 sampled clients (clients A and C), and for 1 additional client (client G), the facility falled ensure staff were trained to competency to implement and document client (S' risk plan and interventions to prevent pressure wounds and failed to provide clients A and G their prescribed diet with pureed consistency. Findings include: 1. The facility's reports to the Bureau of	{W 000}	INITIAL COMMENTS		{W 0	000}			
	{W 191}	post certification revisithe investigation of completed on 5/21/18. This visit was in conjucertification revisit to recertification revisit to recertification and state COMPLAINT #IN001 Dates of Survey: Aug Facility number: 000 Provider number: 15 AIM number: 100243 The following federal state findings in account 483.430(e)(2) STAFF For employees who was toward clients' behave This STANDARD is a Based upon observatives for 2 of 4 sams C), and for 1 addition failed ensure staff we implement and docur interventions to preventially findings include:	sit completed on 7/10/15 to complaint #IN00172930 5. unction with a post a pre-determined full ste licensure survey. 72930: Not corrected. gust 17 and 18, 2015. 771 G251 3430 deficiencies also reflect rdance with 460 IAC 9. TRAINING PROGRAM work with clients, training and competencies directed ioral needs. not met as evidenced by: tion, interview and record pled clients (clients A and al client (client G), the facility are trained to competency to ment client C's risk plan and ent pressure wounds and ts A and G their prescribed iistency.	{W 1	91}			
	ARORATORY I			F	TITLE			(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		15G251	B. WING _			R-C 8/18/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 511 COUNTRY CLUB LN ANDERSON, IN 46015		10/10/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
{W 191}	reviewed on 8/17/15 dated 8/4/15 at 10:00 completing a skin ch open wound on [clien her buttocks approxi (by) 1 cm. Staff appli Corrective action ind assessed the wound and "no concerns we nurse instructed staff treatment. The repor wound care treatmer clinic, and an appoin care in regards to the to monitor the area frinfection and healing checks. Staff will cor wounds to the Program Direction and the program Direction and care clinic was 8/12/15, she was taked identified) on 8/7/15 Factual findings indiction to the program Direction and staff was instructed to no [client C.][Client on [client C.][Client on assessments on a dacontinue to be reported.	bilities Services (BDDS) were at 3:35 PM. A BDDS report DPM indicated "while eck, staff discovered a new at C's] left inner thigh near mately 1 cm (centimeter) x at ded prn (as needed cream.)" icated the group home nurse and no signs of infection ere noted." The group home for to continue Balmex to indicated client C received at through a wound care then the wound. "Will continue for signs and symptoms of the normal property and symptoms of the normal property and the coordinator (PC)." 1. 2. 48/4/15-8/9/15 completed coordinator (PC)." 2. 48/4/15-8/9/15 completed coordinator (PC)." 2. 48/4/15-8/9/15 completed coordinator (PC)." 3. 48/4/15-8/9/15 completed coordinator (PC)." 3. 48/4/15-8/9/15 completed coordinator (PC)." 48/15-8/9/15 completed coordinator (PC)."	{W 19			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		15G251	B. WING _			R-C 08/18/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 511 COUNTRY CLUB LN ANDERSON, IN 46015	ı	00/10/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{W 191}	or wound care as at that this wound is a immobility and obes "Evidence supports" Client C's record wat PM. A Risk Plan up C was at risk for imported by repose the relieved by repose prompting to reposit functional alignment C] has a wheelchair can do independent back she can mane comfortable position however uses adult of accidents. Staff an eeded. [Client C] is needs to use the restream and t	CP (primary care physician) opropriate. The findings are result of diabetes diagnosis, ity." The conclusion indicated staff followed protocols." Its reviewed on 8/17/15 at 2:50 odated 4/9/15 indicated client paired skin integrity and ed integrity) "results in open ores, infection and pain. It to keeping the skin intact is ressure freePressure can sitioning the client or ition and encouraging to when sitting upright. [Client or it that leans back which she also which she also which she is the chair is leaned uver herself into a more in[Client C] is continent, incontinent products in case saist her with changing, as a sable to tell staff when she estroom. Staff will ensure they of client C] when she needs to ind will assist her in cleaning using the restroom" Facility dated 8/7/15 in the ent C was seen for a pressure ply Balmex 11.3% cream we up with specialists and over the propositioning every 1 hours breakdown due to immobility.	{W 19			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		15G251	B. WING			R-C 08/18/2015
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 511 COUNTRY CLUB LN ANDERSON, IN 46015	<u> </u>	00/10/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{W 191}	client C was seen for Recommendations in pressure reduction a chair. Discussed frad do (sic) to decrease documentation indicitation in the record in the record repositioned and toi August 1-10, 2015 from the record at 6:00 AM, 12:00 Prositions hourly-whimpersonal reposition every 2 hrough and the spread sheet." Ther 6:00 AM on 8/3/15, no documentation on 8/4/15, 8/6/15, 8/7/11 A nursing note date indicated client C's fragile," and indicated cream and "encourabedrest (time of day pressure in addition hour." A note dated 8/14/1 Director (PD) in the informed that [client recliner to sit on at contact the contact to the contact the contact the informed that contact the contact the informed that [client recliner to sit on at contact the contact	facility dated 8/12/15 indicated or her pressure ulcer. Indicated "Continue strict and repositioning while in gility of healed area to open d tensile strength." The visit cated "wounds improved since "AR (medication administration d indicated client C was leted every 2 hours from from 12:00 AM until 10:00 PM. ent C was to change positions is a space for documentation and 8:00 PM. "Change le in w/c (wheelchair), ours while asleep in bed. It being completed and on the was no documentation at 8/7/15 and 8/8/15. There was if repositioning at 12:00 PM on 5, 8/10/15 and 8/11/15. If the strength is in the record wound was healed, "skin very end client C was to use Balmex and to take 30 minute of the word wound was healed, "skin very end client C was to use Balmex and to take 30 minute of the word wound was healed, "skin very end client C was to use Balmex and to take 30 minute of the word wound was healed, "skin very end client C was to use Balmex and to take 30 minute of the word word word was healed, "skin very end client C was to use Balmex and the word word word was healed, "skin very end client C was to use Balmex and the word word was healed, "skin very end client C was to use Balmex and the word word was healed, "skin very end client C was to use Balmex and the word word word was healed, "skin very end client C was to use Balmex and the word word word word word word word word	{W 19	1}		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION IG	. ,	ATE SURVEY OMPLETED
		15G251	B. WING _			R-C 08/18/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 511 COUNTRY CLUB LN ANDERSON, IN 46015		00/10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{W 191}	in them. While PD wit was noted that the were individuals in the not able to sit in them observation that it we [client C], but to the program if more reclient C] was very pleased smile, when PD aske helpful. She stated thappy to have additicular, Elient C request will be made Staff at Day services recliner to sit in where each hour." The group home nur 8/18/15 at 11:14 AM pressure sores had be client C was now to be prevent future presses She indicated the docomplete regarding reclient C was reviewed Observations were con 8/18/15 from 2:20 sat in her standard we cushion. There were services common and used by other clients.	re were always people sitting as observing the day service, majority of the time there he recliners and [client C] was in. It was the PD's build be beneficial not only to other clients at the day iners were purchased. [Client as evidenced by a huge and if more recliners would be not it would make her very onal recliners in which she indations: 1. Day service is in cliners for the clients to relax, [C] when she is repositioned. A set to [Area Director (AD)]. 2. It is should offer [client C] at in she is being repositioned where wounds from developing. It is should be repositioned hourly to the propositioning and toileting diversity. It is should at the day services of PM until 2:35 PM. Client C wheelchair sitting on a gel two recliners in the day ea, both of which were being it.	{W 15			
		s able to get out of her lay services, she indicated				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	I` '		X3) DATE SURVEY COMPLETED	
		15G251	B. WING _			R-C 08/18/2015	
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 511 COUNTRY CLUB LN ANDERSON, IN 46015	<u>'</u>	30/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{W 191}	she was not able to repositions herself, shift her position slig DSP (Direct Support interviewed on 8/18/if client C was out of time at day services, indicated client C recassist her out of her toilet. DSP #1 indicabathroom at the fron indicated client C was every two hours. She staff recorded any dictient C in the electrothere was a space in 12:00 AM, 8:00 AM, there was a paper recelectronic document access to the record. A blank Turning/Repused for documentin schedule was review and indicated space. AM until 4:00 AM early A Repositioning Sch services was review indicated for the week was repositioned for Wednesday, Thursd AM until 4:00 PM and was repositioned 4 to and Tuesday. The services was review and truesday. The services was repositioned 4 to and Tuesday. The services was review and Tuesday. The services was repositioned 4 to and Tuesday. The services was repositioned 4 to and Tuesday. The services was review and Tuesday. The services was review and Tuesday. The services was review and and Tuesday.	do so. When asked how she she wiggled in her chair to htly. Staff) #1 at day services was 15 at 2:22 PM. When asked her wheelchair during her she stated, "Not a lot," and quired the use of a lift to wheelchair and onto the ted the lift stayed in the tof the day service. DSP #1 as toileted and repositioned in increase at an regards to toileting price record and indicated in the record to document at and 4:00 PM. She indicated for a cord in addition to the ation, but she did not have cositioning Schedule to be golient C's repositioning yed on 8/18/15 at 3:50 PM as for repositioning from 6:00 ch day on an hourly basis.	{W 1!	91}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	' '	DATE SURVEY COMPLETED
		15G251	B. WING _			R-C 08/18/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 511 COUNTRY CLUB LN ANDERSON, IN 46015	I	00/10/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{W 191}	Staff training record 4:41 PM and indical service staff had be and toileting client of The group home nu 8/18/15 at 4:00 PM initiated the paper of electronic MAR wood documentation. She documentation was electronic record an implemented trainin repositioned every be documented each to and toileted. 2. During observation 8/17/15 from 4:13 P G were served a reconsistency with lur Staff #3 was intervie When asked about the food was pizza a blender for 5 minutes smooth and with no best we can get it." Client A's record wa PM. A risk plan date was at high risk for was to receive a pu Client G's record wa PM. A nutritional as indicated client G w	ted group home staff and day en trained on repositioning C on 8/7/15. Irse was interviewed on and indicated she had locumentation as the uld be too lengthy for hourly endicated the paper a supplement to the distaff should have go to ensure client C was nour and staff should have me client C was repositioned on at the group home on M until 5:59 PM, clients A and dorange food ground into a mps. Ewed on 8/17/15 at 5:50 PM. the consistency, she indicated and it had been ground in a less. She indicated the food was lumps, and stated, "It's the last reviewed on 8/18/15 at 1:28 led 5/6/15 indicated client A choking and indicated she	{W 15	91}		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		15G251	B. WING				-C 18/2015
NAME OF PE	ROVIDER OR SUPPLIER		<u>.l</u>	51	TREET ADDRESS, CITY, STATE, ZIP CODE 11 COUNTRY CLUB LN NDERSON, IN 46015	<u> </u>	10/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 191}	at 1:14 PM and indicated a smooth consister pureeing them. Appear pudding." Staff #3's Diet Texture dated 8/3/15 was reviand indicated staff #3 nurse to competency The group home nurs 8/18/15 at 1:14 PM at trained on the guidelit was smooth with the indicated if staff were being served to smooth offer a substitute that to pureed consistency. This deficiency was consistency.	ated "All foods are prepared and by grinding and then arance is smooth like E Verification of Competence is wed on 8/18/15 at 2:00 PM and been trained by the to prepare pureed food. E was interviewed on and indicated staff had been are to ensure pureed food texture of pudding. She unable to blend the food of the consistency, they were to could be prepared properly y. Littled on July 10, 2015. The ment a systemic plan of reoccurrence.	{W 1				
	examinations of each	ride or obtain annual physical client that at a minimum n of vision and hearing.					
	Based upon record re	not met as evidenced by: eview and interview, the 3 sampled clients (client C) ion examination was					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		15G251	B. WING			R-		
NAME OF PR	ROVIDER OR SUPPLIER	190291	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 511 COUNTRY CLUB LN ANDERSON, IN 46015	 E	08/ <i>°</i>	18/2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE		(X5) COMPLETION DATE	
{W 323}	PM and failed to indic C's vision status. A vision examination the group home nurse at 1:30 PM and indicator yearly vision chectors. The group home nurse 8/18/15 at 1:30 PM at an updated vision examination examination and provided the state of the sta	reviewed on 8/17/15 at 2:50 cate an examination of client dated 4/16/14 provided by e was reviewed on 8/18/15 ated client C was to return ks. se was interviewed on and indicated there was not amination for client C. sited on July 10, 2015. The ment a systemic plan of reoccurrence. SERVICES side clients with nursing the with their needs. not met as evidenced by: n, record review and a nursing services failed for 1 client C) to ensure staff integrity risk plans and	{W 3					
		o the Bureau of oilities Services (BDDS) were at 3:35 PM. A BDDS report						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	COM	TE SURVEY MPLETED
		15G251	B. WING		l	R-C 8/18/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 511 COUNTRY CLUB LN ANDERSON, IN 46015	<u> </u>	0/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{W 331}	completing a skin of open wound on [clie her buttocks approx (by) 1 cm. Staff app Corrective action in assessed the wound and "no concerns wound care instructed state treatment. The repowound care treatment clinic, and an appoin care in regards to the to monitor the area infection and healing checks. Staff will cowounds to the Program Direpressure ulcer indict the following day. Wound care clinic wound ca	on PM indicated "while neck, staff discovered a new ent C's] left inner thigh near imately 1 cm (centimeter) x lied prn (as needed cream.)" dicated the group home nurse d and no signs of infection ere noted." The group home ff to continue Balmex rt indicated client C received ent through a wound care nament was made to follow up the new wound. "Will continue for signs and symptoms of g on a daily basis through skin intinue to report any new ram Coordinator (PC)." ed 8/4/15-8/9/15 completed ector (PD) into the client C's ated "The nurse assessed her then an appointment with the as not able to be made until ken (sic) (location not for her health and safety." Incated client C was assessed (15 and she (the nurse) entinue the Balmex dical facility] visit on 8/7/15, to continue to use the Balmex at C] has a history of skin isbetes, immobility and g watched by wound care	{W 33	1}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		15G251	B. WING _			R-C 08/18/2015	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 511 COUNTRY CLUB LN ANDERSON, IN 46015	DE	00/10/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
{W 331}	immobility and obes "Evidence supports" Client C's record wa PM. A Risk Plan up C was at risk for im broken skin (impairwounds, pressure servention: The key keeping it dry and perelieved by repoprompting to reposifunctional alignment C] has a wheelchaid can do independent back she can mane comfortable position however uses adult of accidents. Staff aneeded. [Client C] in needs to use the rerespond promptly to use the restroom and her thoroughly after A visit to a medical record indicated clied ulcer and was to aptwice daily and folloclient C's PCP.	ge 10 result of diabetes diagnosis, sity." The conclusion indicated staff followed protocols." as reviewed on 8/17/15 at 2:50 odated 4/9/15 indicated client paired skin integrity and ed integrity) "results in open ores, infection and pain. It is to keeping the skin intact is pressure freePressure can sitioning the client or tion and encouraging to when sitting upright. [Client or that leans back which she tity. While the chair is leaned uver herself into a more in[Client C] is continent, incontinent products in case is able to tell staff when she stroom. Staff will ensure they inclient C] when she needs to ind will assist her in cleaning in using the restroom" facility dated 8/7/15 in the cent C was seen for a pressure ply Balmex 11.3% cream we up with specialists and	{W 3		,		
	record indicated an nurse "Assist with re	entry by the group home e-positioning every 1 hours breakdown due to immobility.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G		TE SURVEY
		15G251	B. WING			R-C
	ROVIDER OR SUPPLIER	100201		STREET ADDRESS, CITY, STATE, ZIP COD 511 COUNTRY CLUB LN ANDERSON, IN 46015	•	08/18/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
{W 331}	client C was seen for Recommendations in pressure reduction a chair. Discussed fraged of (sic) to decreased documentation indical last visit." An August, 2015 MA record) in the record repositioned and toile August 1-10, 2015 frage Beginning 8/3/15 clie hourly and there was at 6:00 AM, 12:00 Ph positions hourly-while reposition every 2 hourly and there was at 6:00 AM on 8/3/15, 8 no documentation of 8/4/15, 8/6/15, 8/7/18 A nursing note dated indicated client C's w fragile," and indicated client C's w fragile," and indicated cream and "encourage bedrest (time of day pressure in addition thour." A note dated 8/14/15 Director (PD) in the recliner to sit on at day expressed that when on the recliners, there	acility dated 8/12/15 indicated ther pressure ulcer. Idicated "Continue strict and repositioning while in illity of healed area to open a tensile strength." The visit ated "wounds improved since are developed the every 2 hours from the properties of the every 2 hours from the every 3 hours from the every 4 hours from	{W 33			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	· ,	(X3) DATE SURVEY COMPLETED	
		15G251	B. WING		R-C		
	NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 511 COUNTRY CLUB LN ANDERSON, IN 46015		08/18/2015	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG			(X5) COMPLETION DATE	
{W 331}	it was noted that the were individuals in the not able to sit in ther that it would be beneated to the other client recliners were purch pleased as evidence asked if more reclines stated that is would additional recliners in Recommendations: additional recliners for particular, [client C] or request will be made Staff at Day services recliner to sit in where each hour." The group home nur 8/18/15 at 11:14 AM pressure sores had client C was now to prevent future press. She indicated the docomplete regarding client C was reviewed Observations were con 8/18/15 from 2:20 sat in her standard woushion. There were services common arrused by other clients. Client C was interviewed the was not able to she was not able to sh	majority of the time there he recliners and [client C] was h. It was the PD observation eficial not only to [client C], ts at the day program if more hased. [Client C] was very has do by a huge smile, when PD hers would be helpful. She hase her very happy to have have have have have have have have have her very happy to have have her very happy to have have her very happy to have have have her very have have have have have her very have hav	{W 33	1}			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	COMPLET	(X3) DATE SURVEY COMPLETED R-C		
		15G251	B. WING		08/18/	2015	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 511 COUNTRY CLUB LN ANDERSON, IN 46015			2010	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		DED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
{W 331}	shift her position slig DSP (Direct Suppor interviewed on 8/18/if client C was out of time at day services indicated client C re assist her out of her toilet. DSP #1 indicated client C was every two hours. Sh staff recorded any d client C in the electric there was a space in 12:00 AM, 8:00 AM, there was a paper re electronic document access to the record A blank Turning/Regused for documentin schedule was review and indicated space AM until 4:00 AM each A Repositioning Sch services was review indicated for the wew was repositioned for Wednesday, Thursd AM until 4:00 PM ar was repositioned 4 to and Tuesday. The sedocument for reposicient C.	t Staff) #1 at day services was /15 at 2:22 PM. When asked f her wheelchair during her , she stated, "Not a lot," and quired the use of a lift to wheelchair and onto the ated the lift stayed in the at of the day service. DSP #1 as toileted and repositioned e indicated the day services ata in regards to toileting onic record and indicated in the record to document at and 4:00 PM. She indicated ecord in addition to the tation, but she did not have	{W 33 ⁻				

A. BUILDING R-C 15G251 B. WING 08/18/201	015
06/16/201	015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
511 COUNTRY CLUB LN	
REM OCCAZIO LLC ANDERSON, IN 46015	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	(X5) MPLETION DATE
(W 331) Continued From page 14 initiated the paper documentation as the electronic MAR would be too lengthy for hourly documentation. She indicated the paper documentation was a supplement to the electronic record and client C should have been repositioned every hour and staff should have documented each time client C was repositioned and toileted. This federal tag relates to complaint #IN00172930. This deficiency was cited on May 21, 2015 and July 10, 2015. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-6(a) W 436 W 436 W 436 W 436 W 436 The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide adaptive equipment (customized wheelchair) to meet client C's needs for mobility and positioning to address pressure ulcers. Findings include:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15G251	15G251 B. WING		R-C 08/18/201			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 511 COUNTRY CLUB LN ANDERSON, IN 46015		10/10/2013		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE		ACTION SHOULD BE COM TO THE APPROPRIATE	
W 436	reviewed on 8/17/15 dated 8/4/15 at 10:00 completing a skin ch open wound on [clien her buttocks approxi (by) 1 cm. Staff appl Corrective action ind assessed the wound and "no concerns we nurse instructed staff treatment. The repor wound care treatment clinic, and an appoint care in regards to the to monitor the area frinfection and healing checks. Staff will cor wounds to the Program Direction of the Program Direction of the program Direction of the program Direction of the following day. Wound care clinic was 8/12/15, she was taked identified) on 8/7/15. Factual findings indiction of the program of the following day. Wound care clinic was 8/12/15, she was taked identified) on 8/7/15. Factual findings indiction of the program of the following day. Wound care clinic was 8/12/15, she was taked identified on 8/6/15. Factual findings indiction of the program of the following day. Wound care clinic was 8/12/15, she was taked identified on 8/6/15. Factual findings indiction of the following day. Wound care clinic was 8/12/15, she was taked identified on 8/7/15. Factual findings indiction of the following day. Wound care clinic was 8/12/15, she was taked identified on 8/7/15. Factual findings indiction of the following day. Wound care clinic was 8/12/15, she was taked identified on 8/7/15. Factual findings indiction of the following day. Wound care clinic was 8/12/15, she was taked identified on 8/7/15. Factual findings indiction of the following day. Wound care clinic was 8/12/15, she was taked identified on 8/7/15. Factual findings indiction of the following day.	to the Bureau of bilities Services (BDDS) were at 3:35 PM. A BDDS report DPM indicated "while eck, staff discovered a new at C's] left inner thigh near mately 1 cm (centimeter) x at ded prn (as needed cream.)" icated the group home nurse and no signs of infection ere noted." The group home for to continue Balmex to indicated client C received at through a wound care then the wound. "Will continue for signs and symptoms of the normal point of the client C's at ded "The nurse assessed here then an appointment with the last not able to be made until then (sic) (location not for her health and safety." Cated Client C was assessed at 5 and she (the nurse) intinue the Balmex ical facility] visit on 8/7/15, or continue to use the Balmex to Cl has a history of skin abetes, immobility and practiced watched by wound care	W 4	36				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15G251	B. WING			R-C 08/18/2015		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 511 COUNTRY CLUB LN ANDERSON, IN 46015	I	00/10/2013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
W 436	be made to either P or wound care as at that this wound is a immobility and obes. Client C's record wat PM. A Risk Plan up C was at risk for important broken skin (impaired wounds, pressure some Prevention: The key keeping it dry and post prompting to reposit functional alignment C] has a wheelchair can do independent back she can mane comfortable position client C had a custon her on 5/13/15 and During observation from 4:13 PM until 5 standard wheelchair was still uncertain of the stat ordered for her or of broken foot rests. A visit to a medical to Recommendations in pressure reduction at the stat ordered for her or of processure reduction at the stat ordered for her or of broken foot rests.	fection. Regular follow ups will CP (primary care physician) opropriate. The findings are result of diabetes diagnosis, iity." as reviewed on 8/17/15 at 2:50 adated 4/9/15 indicated client paired skin integrity and ed integrity) "results in open ores, infection and pain. It to keeping the skin intact is ressure freePressure can sitioning the client or ion and encouraging to when sitting upright. [Client of that leans back which she ally. While the chair is leaned uver herself into a more in"The record indicated mized wheelchair ordered for again on 6/8/15. at the group home on 8/17/15 is:59 PM, client C sat in a	W 43	36				

· · · · · · · · · · · · · · · · · · ·	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	15G251	B. WING _			R-C 08/18/2015	
NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 511 COUNTRY CLUB LN ANDERSON, IN 46015			
PREFIX (EACH DEFICIENCY MUST	INT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE		(X5) COMPLETION DATE
W 436 Continued From page 17 do (sic) to decreased tensil documentation indicated "w last visit." A nursing note dated 8/14/1 indicated client C's wound fragile," and indicated client cream and "encouraged to bedrest (time of day unsperpressure in addition to charmour." A note dated 8/14/15 entern Director (PD) in the record informed that [client C] wourecliner to sit on at day servex expressed that when she won the recliners, there were in them. While PD was obsit was noted that the majority were individuals in the reclinot able to sit in them. It was observation that it would be [client C], but to the other coprogram if more recliners word in the program of more recliners word in the program of additional recould sit. Recommendation need of additional recliners in particular, [client C] when request will be made to [And Staff at Day services should recliner to sit in when she is each hour."	wounds improved since "15 in the record was healed, "skin very at C was to use Balmex take 30 minute ecified) to relieve anging position every "red by the Program indicated the "PD was alld like to have a vice. [Client C] wanted to be able to sit e always people sitting serving the day service, ity of the time there iners and [client C] was as the PD's e beneficial not only to clients at the day were purchased. [Client idenced by a huge fore recliners would be would make her very ecliners in which she as: 1. Day service is in as for the clients to relax, an she is repositioned. A rea Director (AD)]. 2. Id offer [client C] a is being repositioned	W	436			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED				
		15G251	B. WING		R-C 08/18/2	2015		
	NAME OF PROVIDER OR SUPPLIER REM OCCAZIO LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 511 COUNTRY CLUB LN ANDERSON, IN 46015	1 00/10/2	2013		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		EFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD		OULD BE CO	(X5) OMPLETION DATE
W 436	[wheelchair comparhandling the order for work has been filled been done, waiting handling the repair of filled out the paper of resending. Did state owns the broken chowith getting the new An entry by the growthe record indicated wheelchair companicient C's wheelchair companicient C's wheelchair compatible status of client C's wordered. She was undelay of client C's wordered. She was to use wheelchair to assist Observations were on 8/18/15 from 2:2 sat in her standard or cushion. There were services common a used by other client. Client C was interview. When asked if she is wheelchair while at she was not able to repositions herself, shift her position slight.	and her assessment has for chair to arrive. [Name] is claims the doctor hasnt (sic) work they had wrong doctor, at to me that she (client C) air and it will be repaired even one." The home nurse on 8/18/15 in the nurse had called the yin regards to the status of ir and had left a message. The was interviewed on the wheelchair that had been nucertain as to the cause of the wheelchair. She indicated a gel cushion on her with pressure on her skin. The completed at the day services the wheelchair sitting on a gel to two recliners in the day rea, both of which were being services, she indicated do so. When asked how she she wiggled in her chair to	W 436					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
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		15G251	B. WING		08	/18/2015	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 511 COUNTRY CLUB LN ANDERSON, IN 46015			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 436	if client C was out of time at day services, indicated client C requestist her out of her was in the control of	5 at 2:22 PM. When asked her wheelchair during her she stated, "Not a lot," and uired the use of a lift to wheelchair and onto the ed the lift was kept in the	W 43	36			
{W 460}	9-3-7(a) 483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.		{W 46	0}			
	Based upon observareview, the facility fail (client A) and 1 additi provide the prescribe consistency. Findings include: During observation at from 4:13 PM until 5:: served a red/orange to consistency with lump. Staff #3 was interview. When asked about the food was pizza arblender for 5 minutes.	t the group home on 8/17/15 59 PM, clients A and G were food ground into a					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	X2) MULTIPLE CONSTRUCTION a. BUILDING		(X3) DATE SURVEY COMPLETED	
		15G251	B. WING _			R-C 08/18/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 511 COUNTRY CLUB LN ANDERSON, IN 46015	I	06/16/2015	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{W 460}	PM. A risk plan date was at high risk for was to receive a pure Client G's record wat PM. A nutritional as indicated client G was received a pure of Food Consing group home (undate at 1:14 PM and indict to a smooth consist pureeing them. Appudding." The group home nute 8/18/15 at 1:14 PM trained on the guide was smooth with the indicated if staff were being served to smooth group home nute for a substitute that to pureed consistent.	is reviewed on 8/18/15 at 1:28 and 5/6/15 indicated client A choking and indicated she reed diet. It is reviewed on 8/18/15 at 1:45 as reviewed on 8/18/15 at 1:45 as to receive a pureed diet. It is the receive a pureed by the red) was reviewed on 8/18/15 cated "All foods are prepared rency by grinding and then rearance is smooth like It is the receive a pureed food at the receive and the food receive	{W 46	60}			